STATE OF WASHINGTON

OFFICE OF
INSURANCE COMMISSIONER
TECHNICAL ASSISTANCE ADVISORY
TAA 2000-07

TO: **Health Care Service Contractors, Health Maintenance Organizations, and Active A&H and Group Disability Insurers**

SUBJECT: **Individual and Small Group Filings**

DATE: **December 13, 2000**

This technical assistance advisory (TAA) replaces TAA 96-01, issued on September 20, 1996. It replies to questions that may arise in preparing future form and rate filings.

1. **Question: Historically, insurance carriers have been able to charge a different premium for spouses of subscribers than for subscribers. Can carriers do that now?**

Answer: For health care service contractors (HCSCs), RCW 48.44.022(1)(a) and 48.44.023(3)(a) state that premium rates for individual and small group health benefit plans are based on an adjusted community rate which may be adjusted only for geographic area, family size, age, and wellness activities.

For health maintenance organizations (HMOs), RCW 48.46.064(1)(a) and 48.46.066(3)(a) set the same standards.

For disability insurers, the applicable statutes are RCW 48.20.028(1)(a) and 48.21.045(3)(a).

These statutes do not allow any variation from community rating for any reason other than those listed. In the group market, the spouse's insurance coverage is via the family contract of the employee/subscriber. Therefore, the subscriber/spouse rates are considered to be a family-size issue. However, the rates for the subscriber/spouse must be based on sound factors and must not be in violation of the community rating (pooling) requirements of the statutes cited above.

2. **Question: Are "wellness activities" and "wellness factors" the same thing? If they are, what are they?**

Answer: Wellness activities and wellness factors are the same thing. For the purposes of this discussion, they are defined at RCW 48.43.005(25) as ". . . an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs." This definition applies to HCSCs, HMOs, and disability insurers equally. The Department of Health has written *Washington State Wellness Guidelines*, which expands upon the statute.

RCW 48.44.022(1)(e), 48.44.023(3)(e), 48.46.064(1)(e), 48.46.066(3)(e), 48.20.028(1)(e), and 48.21.045(3)(e) permit a discount for wellness activities to reflect actuarially justified differences in utilization or cost attributed to such programs. This discount is not to exceed 20 percent.

The wellness factors in Washington statutes allow carriers to ask questions of individuals and small groups in order to qualify them for discounts. However, these questions must not be framed in such a way as to amount to the application of underwriting penalties. Additionally, while much of the *Washington State Wellness Guidelines* is directed to company-sponsored programs, such as employee assistance programs (EAPs), the guidelines state that they are applicable to individual policyholders as well. For groups, the discount must apply to the entire group and may not be applied on an employee-by-employee basis. As an example, a carrier may use a "Drug Free Workplace" to provide discounting for wellness factors for a small group, but may not give a per-employee non-smoker discount. An individual policyholder, on the other hand, could receive a discount for being a non-smoker.

3. Question: What is the policy on frequency of individual and small group rate filings?

Answer: "The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually," according to RCW 48.44.022(1)(f), 48.44.023(3)(f), 48.46,064(1)(f), 48.46.066(3)(f), 48.20.028(1)(f), and 48.21.045(3)(f). These statutes allow the Commissioner to accept only one rate filing for individual and small group plans annually. *Annually* is defined as a period of 12 months from the effective date of the last rate filing; filed rates for any policy must be guaranteed for at least one full policy year.

The annual filing may include rates for renewal and new business that account for the effect of trend on a shorter-than-annual basis. Rates for these filings may be varied on an annual, semi-annual, quarterly, or monthly basis. If the carrier prefers to vary rates based on effective dates, rather than annually, the carrier should pre-file the monthly, quarterly, or semi-annual effective date factors in the annual filing for specific group renewal and new business during the designated 12-month period. To illustrate, if a carrier needed to charge an average of $100 per month for all contracts renewing throughout the year, it would be permissible to file effective rates of $99.04 for policies renewing in the first quarter, $99.68 for policies renewing in the second quarter, $100.32 for policies renewing in the third quarter, and $100.97 for policies renewing in the fourth quarter. It would also be permissible to vary rates for policies renewing (or being issued) in a similar manner for the month or half-year during which the issue or renewal takes place.

A carrier may not make monthly or quarterly filings to adjust the annual rate except under extraordinary circumstances in which the Commissioner expressly grants this authority.

If the carrier fails to make an annual filing, the renewal rates will be identical to rates last charged to the group being renewed. New business rates would be those last charged to any group plan. To illustrate, suppose a carrier has quarterly premiums of $100, $110, $120, and $130 and has not submitted a new filing. The new business rate would be $130, and the renewal rate would be identical to the previous premium charged to a specific group or individual plan.

4. Question: What adjustments for geographic factors are allowed?

Answer: RCW 48.44.022(2), 48.44.023(3)(i), 48.46.064(2), 48.46.066(3)(i), 48.20.028(2), and 48.21.045(3)(i) state that adjusted community rates shall pool the medical experience of all individuals or groups purchasing coverage. The geographic factors must be based on credible data or a large study. A carrier must not base its geographic factors on its own experience by geographic area; that would violate the pooling requirements of community rating.

5. Question: Is it possible to make relativity adjustments between plans?

Answer: A carrier may adjust the benefit relativities based on the deductible leverage or other reasonable causes. A carrier must not adjust the benefit relativity of a health benefit plan based on that individual plan's experience; that would violate the pooling requirements of community rating.

6. Question: What children's rates are allowed?

Answer: RCW 48.44.022(1)(b), 48.46.064(1)(b), and 48.20.028(1)(b) state that individuals under age 20 shall be treated as those age 20. Therefore, all dependent children under age 20 enrolled in the same individual benefit plan must be charged the same rate. RCW 48.44.023(3)(b), 48.46.066(3)(b), and 48.21.045(3)(b) state that employees under age 20 shall be treated as those age 20. Although the statutes cited with respect to small group plans address only employee rates for under age 20 and do not specifically address individual/child rates, the Office of Insurance Commissioner takes the position that the small group community rate statutes mirror the individual community rate statutes. Therefore, all dependent children under age 20 enrolled in the same small group benefit plan must be charged the same rate.

7. Question: Must all small group products be offered to all small groups?

Answer: Yes, carriers must not develop small group products that are not offered to all groups under 50.

Finally, as a reminder: As of January 1, 2000, in accordance with RCW 48.20.028(1)(d), 48.21.045(3)(d), 48.44.022(1)(d), 48.44.023(3)(d), 48.46.064(1)(d), and 48.46.066(3)(d), the highest permitted rates for any group shall be no more than 375% of the lowest rates.

If you have questions, please contact our health actuary, Lichiou Lee, at (360) 586-5313 or LichiouL@oic.wa.gov. Additional information on many topics of interest is available on our Website at http://www.insurance.wa.gov.